STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 124013-001**

Trustmark Life Insurance Company
Respondent

Issued and entered
this 1st day of November 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On October 21, 2011, XXXXX (Petitioner) filed a request for expedited external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* In order to receive an expedited external review under PRIRA, a physician must substantiate that the Petitioner's life or health would be seriously jeopardized, or the Petitioner's ability to regain maximum function would be jeopardized, if an expedited review is not granted. In this case, a physician has not documented such conditions. While a physician has not made that substantiation, the Commissioner has determined that the issue in this case merits prompt resolution.

After a preliminary review of the material submitted, the Commissioner accepted the request for external review on a non-expedited basis and the Commissioner assigned the matter to an independent review organization. On October 28, 2011 Petitioner's physician provided a statement but still did not document the need to expedite. However, the OFIR requested that the independent medical reviewer complete the review in the expedited timeframe. The review was completed its review and sent to the Office of Financial and Insurance Regulation on October 28, 2011.

II. FACTUAL BACKGROUND

The Petitioner receives benefits under a Starmark Comprehensive Major Medical Coverage group policy (the certificate) that is underwritten by Trustmark Life Insurance Company (Trustmark). Petitioner has a history of back and neck pain and says she had failed conservative treatments including medication, physical therapy and epidural steroid injections. She seeks preauthorization for coverage of lumbar laminectomy and fusion surgery. Trustmark denied coverage of the procedure on the basis that it is not medically necessary.

The Petitioner appealed the denial through Trustmark's internal grievance process. Trustmark maintained its decision and issued a final adverse determination dated October 18, 2011.

III. ISSUE

Did Trustmark correctly deny Petitioner's request for coverage of laminectomy and fusion surgery?

IV. ANALYSIS

Petitioner's Argument

The Petitioner argues she has been through physical therapy and many tests, injections, and medications but nothing has helped to control her neck and back pain. She is at a loss why her insurer believes her surgery is not medically necessary. She does not know what else to do and her pain is getting worse. She writes:

> I have increased pain in my back and my neck but especially my lower back. I have numbness and pain down both legs all the way to the tips of my toes and my butt. At times I can't walk. I do have limited walking, standing [ability], I can hardly bend from a standing position anymore. Most of the time I have to lift my own legs to put on my shoes. I'm depressed, lost 55 lbs., having trouble sleeping (up to 4 hours a day now) and I can go on. I am asking you to expedite this decision in hopes that I have this surgery because I have resolved all other resources. During the time of the determination CoreSource has accumulated all medical records from my neurosurgeon, pain management and physical therapy which is well over 200 pages of records regarding treatments received.

In a letter of appeal to OFIR dated October 26, 2011 seeking authorization to perform the lumbar laminectomy and fusion Petitioner's neurosurgeon wrote:

> [Petitioner] is currently a patient of mine for severe back pain. She has suffered

> with severe back pain for two years. Her symptoms began on 10/5/09, after she was involved in a motor vehicle accident. She has undergone physical therapy and epidural steroid injections, and had had no relief of her symptomatology. She is currently using a high dose of narcotic analgesics, and she does ahs required an increase, as her medication intolerance has increased and her pain has continued. She is also experiencing numbness in he right lower extremity. She has experienced a profound weight loss of 55 pounds, as well as a new onset of depression, which has been symptomatic for her since her back pain has continued to progress.
>
> Her imaging study reveals a desiccated disc with a disc bulge and foraminal narrowing at L45. She has also undergone a discogram, where concordant pain was found at L45 and L5S1. In view of these finding, I feel it would be to her advantage to proceed with a lumbar laminectomy and fusion at L45 in an attempt to provide pain relief. I am concerned for [Petitioner] in light of her depression, increasing weight loss, and increasing dependency on narcotic analgesics. I have recommended that she undergo this procedure, as I feel it is indicated due to the aforementioned reasons.

Respondent's Argument

In its October 18, 2011 final adverse determination CoreSource on behalf of Trustmark denied Petitioner's requested surgery stating in part:

> A physician specialist has reviewed the medical records pertaining to this service and has determined not to reverse the original decision. The principal reason for this decision is: the case was discussed with Dr. XXXXX who stated surgery was recommended for pain, disc dessication and discogram results. The patient has a discogram that shows concordant pain at L5-S1. However, the patient reports pain at L4-5 as well. The patient has x-rays demonstrating no evidence of spon-dylolisthesis, she has an MRI that demonstrates small disc at L4-5, otherwise normal exam. Given the lack of significant pathology, the requested fusion is not medically necessary.

Commissioner's Review

The Petitioner's certificate provides coverage for medical expenses only when they are medically necessary care and treatment for sickness or injury. The term "medically necessary" is defined in the certificate as:

> A service, drug, or supply that is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury in accordance with generally accepted standards of medical practice in the U.S. at the time the service, drug or supply is provided.

> When specifically applied to a confinement it further means that the diagnosis or treatment of the person's symptoms or condition cannot be safely provided to that person on an outpatient basis.
>
> A service, drug, or supply shall not be considered Medically Necessary if it:
>
> 1. Is Experimental/Investigational, or for research purposes;
> 2. Is provided solely for the convenience of the patient, the patient's family, physician, hospital or any other provider;
> 3. Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment;
> 4. Could have been omitted without adversely affecting the person's condition or the quality of medical care;
> 5. Involves the use of a service, supply or drug not formally approved by the United States Food and Drug Administration; or
> 6. Involves a service, supply or drug not approved for reimbursement by the Centers for Medicare and Medicaid Services or any successor organization.
> 7. Is a misrepresentation of services provided.
>
> Benefit payment is subject to the determination by us that the service, drug or supply is Medically Necessary. The fact that a Physician may prescribe, authorize, or direct a service, drug or supply to be prescribed, does not of itself make it Medically Necessary or covered under this Certificate.

To determine whether lumbar laminectomy and fusion surgery is medically necessary for treatment of Petitioner's condition the case was assigned to an independent review organization (IRO) for review analysis and a recommendation as required by Section 11(6) of the Patient's Right to Independent Review Act, MCL 550.1911(6). The IRO reviewer a practicing physician who is board certified in orthopedic surgery with spine surgery fellowship and has been in practice for more than 15 years. The IRO reviewer is familiar with the medical management of patients with Petitioner's condition and has examined the medical record and the arguments present by the parties. The reviewer provided the following analysis and conclusion:

> [T]he member does not meet coverage criteria for lumbar fusion.…[T]here is no documented evidence of instability, fracture, or tumor associated with the member's symptoms.…[T]he MRIs the member underwent of the lumbar and cervical spine do not demonstrate significant spinal stenosis.…Therefore…lumbar spinal fusion is not medically necessary for treatment of the member's condition.…[T]he member's medical records do not demonstrate a need for lumbar decompression laminectomy.

> Pursuant to the information set forth above and available documentation, the…lumbar laminectomy and fusion are not medically necessary for treatment of the member's condition.

The Commissioner is not required in all instances to accept the IRO's recommendation. However, the IRO recommendation is afforded deference by the Commissioner. In a decision to uphold or reverse an adverse determination, the Commissioner must cite "the principal reason or reasons why the Commissioner did not follow the assigned independent review organization's recommendation." MCL 550.1911(16)(b). The IRO's analysis is based on extensive experience, expertise and professional judgment. The Commissioner can discern no reason why the IRO's recommendation should be rejected in the present case.

The Commissioner concludes that Trustmark's denial of coverage for the Petitioner's requested lumbar laminectomy and fusion surgery is consistent with the terms of the certificate.

V. ORDER

The Commissioner upholds Trustmark's final adverse determination issued October 18, 2011. Trustmark is not required to cover the Petitioner's requested lumbar laminectomy and fusion surgery.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this order may seek judicial review no later than 60 days from the date of this order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton
Commissioner